**COMMONWEALTH OF VIRGINIA**
**SCHOOL ENTRANCE HEALTH FORM**

*Health Information Form/Comprehensive Physical Examination Report/Certification of Immunization*

## Part I - HEALTH INFORMATION FORM

Part I to be completed by parents or guardians of students Ref Code of Virginia § 22.1-270, I.

Student's Name:_____
Last First Middle
Student's Date of Birth: |__|__|__| Sex: |__| Number of Children in Family: |__| State or County of Birth:_____
Mo Day Yr
Student's Social Security # |__|__|__|-|__|__|-|__|__|__|__| or ID#:_____
Student's Address:_____City:_____State:_____Zip: |__|__|__|__|__|
Name of School_____Grade_____
Name of Mother or legal Guardian:_____
Home Phone: |__|__|__|-|__|__|__|-|__|__|__|__| Work Phone: |__|__|__|-|__|__|__|-|__|__|__|__|
Name of Father or Legal Guardian:_____
Home Phone: |__|__|__|-|__|__|__|-|__|__|__|__| Work Phone: |__|__|__|-|__|__|__|-|__|__|__|__|
In case of emergency --if parent or guardian cannot be contacted--contact the following:

1. Name: _____ Complete Phone Number: |__|__|__|-|__|__|__|-|__|__|__|__|
2. Name:_____ Complete Phone Number: |__|__|__|-|__|__|__|-|__|__|__|__|

Birth History (weight, premature and any other problems at birth):_____

_____
ALLERGIES: (food, medicine, insect bites, and any other allergies):_____

| Equipment Used and Specialized Health Care Needed (check all that apply and explain below.*) | | | | Chronic Recurring, and Special Health Conditions (check all that apply and explain below.*) | |
|---|---|---|---|---|---|
| Equipment Used by Child: | | Catheterization: | | | Arthritis (rheumatoid) |
| | Glasses/Contact Lens | | Clean Intermittent Catheterization | | Asthma |
| | Hearing Aid | | External Catheter | | Attention-Deficit/Hyperactivity Disorder |
| | Helmet | | Other: | | Behavioral or Developmental Problems |
| | Wheelchair/Walker | Medical Support Systems: | | | Cerebral Palsy |
| | Other: | | Hickman/Broviac/VAC/MED | | Cystic Fibrosis |
| | | | Mechanical Ventilator | | Dental Problems |
| | | | Oxygen | | Diabetes |
| Specialized health Care Needed: | | | Ventricular Peritoneal Shunt | | Encopresis (involuntary discharge of stool) |
| Activities of Daily Living: | | | Other: | | Enuresis (involuntary discharge of urine) |
| | Bowel/Bladder Training | Ostomies: | | | Head or Spinal Injury |
| | Diapering/Toileting | | Ostomy Care | | Hearing Impairment |
| | Lifting/Positioning | | Other:: | | Heart Disease |
| | Other: | Respiratory Assistance: | | | Kidney Disease |
| Feeding: | | | Percussion | | Muscular Dystrophy |
| | Gastrostomy Feeding | | Postural Drainage | | Seizures |
| | Jejunostomy Tube Feeding | | Suctioning | | Sickle Cell Disease (not trait) |
| | Naso-Gastric Feeding | | Other | | Spina Bifida |
| | Oral Feeding | Specimen Collecting/Testing: | | | Visual Impairment |
| | Total Parenteral Feeding | | Blood Glucose | | Other: |
| | Other: | | Other : | | |

*Explanation:

Describe any family history of chronic illnesses or genetic concerns (please list family member in relation to child [e.g., mother] and name of condition [e.g., anemia, arthritis, cancer, diabetes, heart disease, high blood pressure, kidney disease, mental illness, stroke, tuberculosis]): _____

List names of medical specialists or special clinics caring for your child:_____

Has your child ever been seen by a dentist? Yes |__|, No |__|. If yes, date of last appointment:_____Name of dentist:_____
List all prescription and over-the-counter medications taken regularly by your child:_____

Describe your child's operations, and hospitalizations, if any (reason and date)_____
Describe any other important health-related information about your child:_____

Check here if you want to discuss confidential information with school nurse or other school authority. Yes |__|, No |__|.
Check here if you give permission for the school nurse or other school authority to contact the examining physician to discuss any information contained on this form. Yes |__|, No |__|.
Signature of Parent or Legal Guardian:_____Date: (Mo., Day, Yr.): |__|__|__|

## Part II - COMPREHENSIVE PHYSICAL EXAMINATION REPORT

Part II to be completed by qualified licensed physician. All components, unless otherwise indicated, are to be performed no earlier than twelve months prior to the date child enters kindergarten or elementary school. Ref. Code of Virginia § 22.1-270, A-H

Student's Name:_____
Last First Middle

Date of Birth: |__|__|__| Height:_____ Weight:_____Head Circumference:_____ Blood Pressure:_____
Mo. Day Yr.

Hemoglbin:_____ gms or Hematocrit:_____% Urine: Albumin_____Sugar:_____Other:_____

Results of Mantoux tuberculin skin test, optional (may be required in high-risk groups):_____mm. Date of test: |__|__|__|
Mo. Day Yr.

If performed, date of most recent blood lead level: |__|__|__| Results:_____ µg/dL
Mo. Day Yr.

Visual Screening:

Distance visual acuity screening results, without correction: Right Eye 20/_____ Left Eye 20/_____ Both Eyes 0/_____

Distance visual acuity screening results, with correction: Right Eye 20/_____ Left Eye 20/_____ Both Eyes 0/_____

If performed stereopsis screening results: Pass:_____ Fail:_____

Child to be rescreened? Yes |__|, No |__|. Child to be referred? Yes |__|, No |__|.

Hearing:

Hearing screening results: Right Ear_____ Left Ear_____ Equipment used:_____

If performed, hearing evaluation results: Right Ear_____ Left Ear_____

If indicated, Tympanogram: Normal:_____ Abnormal_____

Child to be rescreened? Yes |__|, No |__|. Child to be referred? Yes |__|, No |__|.

| Systems Examination | | Examined | Not Examined | Comments About Finding |
|---|---|---|---|---|
| General Appearance | | | | |
| Nutritional Status | | | | |
| Posture/Motor Behavior | | | | |
| Skin | | | | |
| Head | | | | |
| Eyes: | External | | | |
| | Fundi | | | |
| Ears: | External and Canal | | | |
| | Tympanic Membrane | | | |
| Nose | | | | |
| Throat | | | | |
| Mouth/Teeth | | | | |
| Neck | | | | |
| Heart | | | | |
| Lungs | | | | |
| Abdomen | | | | |
| Genitalia (Tanner Stage) | | | | |
| Bones, Joints, Muscles | | | | |
| Neurological | | | | |
| Estimated Developmental Level: | Cognitive Development | | | |
| | Speed/Language Development | | | |
| | Social/Emotional Development | | | |
| | Health Behaviors/Health Habits | | | |
| Other: | | | | |

Summary of abnormal physical finding, if any:_____

_____

_____

Medical diagnoses: _____

_____

Describe specifically what, if any, conditions are found that would identify the child as having a disability, including conditions that might require (1) educational evaluation, (2) environmental adjustment, or (3) activity limitation:_____

_____

_____

Assessment:_____

_____

Recommendations and referrals made, if any:_____

_____

_____

Physician's Address:_____City:_____ State:_____ Zip:|__|__|__|__|__|

Physician's Name (print):_____ Phone No.: |__|__|__|-|__|__|__|-|__|__|__|__|

Signature of Physician:_____Date (Mo., Day, Yr.): |__|__|__|

## Part III - CERTIFICATION OF IMMUNIZATION

Part III to be completed by a physician or health department official

Student's Name:_____ Date of Birth: |__|__|__|
Last First Middle

Student's Social Security # : |__|__|__|-|__|__|-|__|__|__|__| or ID#:_____

Name of Parent/Guardian:_____

| IMMUNIZATION | RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN | | | | |
|---|---|---|---|---|---|
| Diphtheria, Tetanus, Pertussis (DTP, DTaP) | 1. | 2. | 3. | 4. | 5. |
| Diphtheria, Tetanus (DT) or Td given after 7 years of age) | 1. | 2. | 3. | 4. | 5. |
| Poliomyelitis (OPV or IPV) | 1. | 2. | 3. | 4. | 5. |
| Haemophilus Influenzae Type b (Hib Conjugate Vaccine) | 1. | 2. | 3. | 4. | |
| Measles (Rubeola) | 1. | 2. | Serological Confirmation of Measles Immunity: | | |
| Rubella | 1. | 2. | Serological Confirmation of Rubella Immunity | | |
| Mumps | 1. | 2. | Other (List type and date received) | | |
| Measles, Mumps, Rubella (MMR vaccine) | 1. | 2. | | | |
| Hepatitis B Vaccine (HBV) | 1. | 2. | 3. | Other: | |
| Varicella Vaccine | 1. | 2. | Other: | Other: | |
| Rotavirus Vaccine | 1. | 2. | 3. | Other: | |

**MEDICAL EXEMPTION:** As specified in the code of Virginia § 22.1-271.2, C (ii), I certify that administration of the vaccine(s) designated below would be detrimental to the student's health. The vaccine(s) is (are) specifically contraindicated because (please specify):_____
_____
_____
_____

DOTP/DTaP: [___]; DT/Td: [___]; OPV/IPV:[____]; Hib: [____]; HBV: [____]; Measles: [____]; Rubella: [____]; Varicella: [___]

This contraindication is permanent: [__] or temporary [__] and expected to preclude immunizations until: Date (Mo., Day, Yr.): |__|__|__|

**RELIGIOUS EXEMPTION:** The code of Virginia allows a child an exemption from receiving immunizations required for school attendance if the student or the student's parent/guardian submits an affidavit to the school's admitting official stating that the administration of immunizing agents conflicts with the student's religious tends or practices. Any student entering school must submit this affidavit on a CERTIFICATE OF RELIGIOUS EXEMPTION (Form CRE-1), which may be obtained at any local health department, school division superintendent's office or local department of social services Ref. Code of Virginia § 22.1-271.2, C (I).

I certify that this student has received at least one does of each of the vaccines required by the State Board of Health for attending school and that the student has a plan for the completion of his/her requirements within the next 90 days (conditional enrollment).

Signature of Physician or health Department Official:_____ Date (Mo., Day, Yr.): |__|__|__|

I certify that his student is ADEQIATELY IMMUNIZED in accordance with the MINIMUL requirements for attending school prescribed by the State Board of Health's Regulations for the Immunization of School Children (For information or questions or immunization requlations, please call your local health department or the Virginia Department of health Division of Immunization, at 1-800-568-1929

Signature of Physician or health Department Official:_____ Date (Mo., Day, Yr.): |__|__|__|